CHAPTER 7
HEALTHY OLDER ADULTS

> Goal: To improve the health and quality of life for older adults and, by 1990, to reduce the average annual number of days of restricted activity due to acute and chronic conditions by 20 percent, to fewer than 30 days per year for people aged 65 and older.

If longer life has been one of society's most conspicuous accomplishments, there is compelling need now for another: a better, healthier life for older people.

More Americans today live to older age than ever before. Whereas in 1900 there were only three million Americans aged 65 and over, making up four percent of the population, now there are 24 million, composing 11 percent. By the year 2030, people 65 and over will number 50 million and comprise 17 percent of our population.

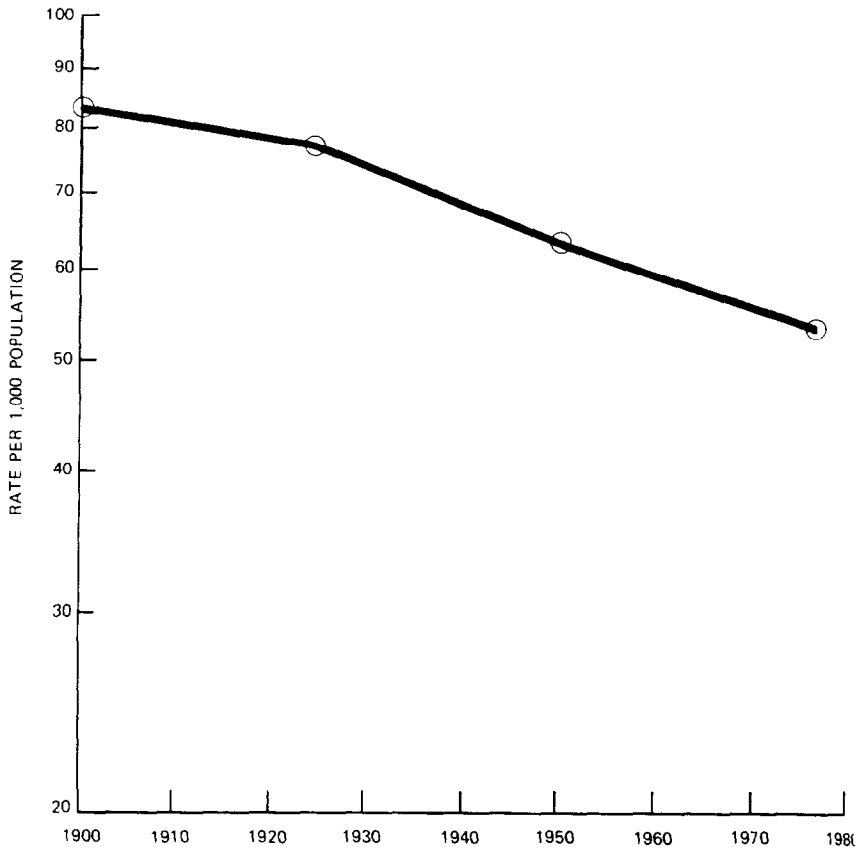
The death rate for older Americans compares well with that for older citizens of other countries, although we still rank behind countries such as Japan and Iceland (Figure 7-B). For all Americans over 65 the death rate is down from about 8,300 per 100,000 in 1900 to about 5,400 in 1977 (Figure 7-A). And for those 65 to 74, it has been amost halved--from 5,600 per 100,000 in 1900 to 3,100 in 1977.

But we have cause for concern.

The reasons for considering age 75 as marking the start of old age are mostly social, rather than biological. Aging is a subtle, gradual, lifetime

FIGURE 7-A

DEATH RATES FOR AGES 65 YEARS AND OVER: UNITED STATES, SELECTED YEARS 1900-1977

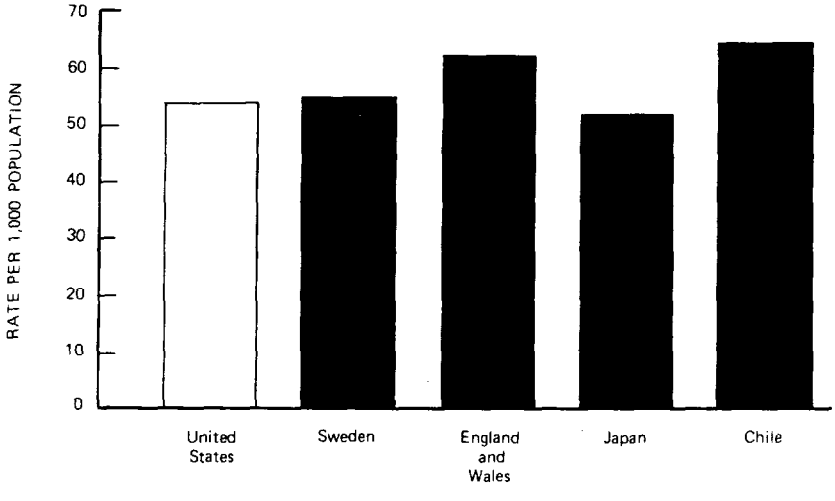


NOTE: 1977 data are provisional; data for all other years are final. Selected years are 1900, 1925, 1950, 1977.

Source: National Center for Health Statistics, Division of Vital Statistics.

FIGURE 7-B

DEATH RATES FOR AGE 65 YEARS AND OVER: SELECTED COUNTRIES, 1975

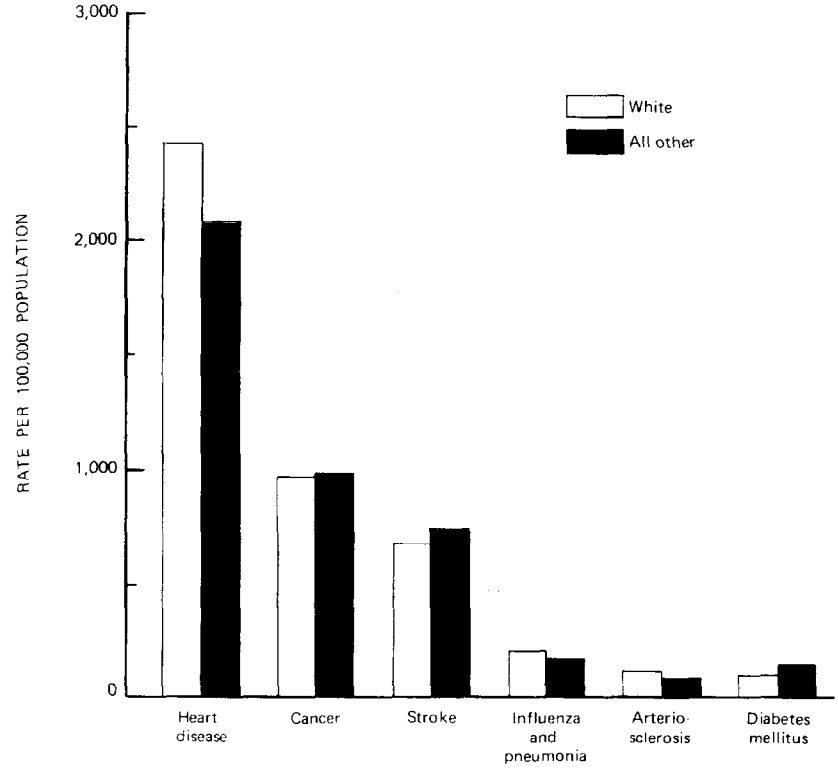


NOTE: The most recent year of data for Chile is 1971.

Sources: United States, National Center for Health Statistics, Division of Vital Statistics; other countries, United Nations.

FIGURE 7-C

MAJOR CAUSES OF DEATH FOR AGES 65 YEARS AND OVER: UNITED STATES, 1976



Source: Based on data from the National Center for Health Statistics, Division of Vital Statistics.

process and there are startling contrasts in how individuals age. Even within an individual, different body systems age at different rates.

In short, age 65 does not mark the start of any inevitable uniform decline in physical and psychological functioning.

Nevertheless, the proportion of people with health problems increases with age and, as a group, the elderly are more likely than younger persons to suffer from multiple, chronic, and often disabling conditions.

Eighty percent of our older people have one or more chronic conditions and their medical treatment accounts for about 30 percent of the Nation's health care expenditures.

The long-term goal of a health promotion and disease prevention strategy for our older people must not only be to achieve further increases in longevity, but also to allow each individual to seek an independent and rewarding life in old age, unlimited by many health problems that are within his or her capacity to control.

"Quality of life" is a phrase sometimes used to describe the latter goal. It is not something readily measured--but activity limitations due to illness or injury clearly compromise the quality of an older person's life.

Over the last decade, the proportion of people over 65 who have had to place limits on themselves, primarily because of chronic conditions, has fluctuated between an estimated 42 and 47 percent--only slightly less than half the 24 million elderly.

And the average number of days of limitation has changed little in recent years, ranging from 31 to 38 days per person per year.

But a large portion of chronic activity limitation stems from respiratory conditions such as chronic bronchitis and emphysema, and reductions in cigarette smoking among adults should lower the incidence of these conditions by 1990.

Moreover, a relatively small reduction in the incidence of strokes or a significant increase in persons protected from influenza and its complications could produce a noticeable reduction in activity limitation.

There is much that can and should be done to help make older Americans healthier and better able to function independently.

Subgoal: Increasing the Number of Older Adults Who Can Function Independently

As do younger people, older Americans hope for a state of well-being which would allow them to perform at their highest functional capacity on physical, psychological, and social levels.

Their greatest fear is of being helpless, useless, sick, or unable to care for themselves.

Despite a common misconception, most elderly Americans can and do remain in their own homes. In 1975, 77 percent had their own households--51 percent living with a spouse, 26 percent living alone--and 18 percent lived with someone other than a spouse. Only five percent lived in institutions.

Although the majority of the elderly are vigorous and completely independent, there are 45 percent with certain activity limitations--some associated with mental disabilities, but most due to physical handicaps caused by heart conditions, arthritis and rheumatism, hearing loss, and visual impairments.

Up to 20 percent of older people--from one-third to one-half of those with any activity limitations--are handicapped in ability to move about freely,

compared with two or three percent of the 17 to 64 year old population.

Yet it must be reemphasized that only five percent reside in institutions--and many of these are temporary residents who are recovering from illness and will return to the community.

With adequate social and health services, a greater proportion of the elderly could maintain a relatively independent lifestyle and vastly improve the quality of their lives.

Disease-Related Factors of Dependency

Severe physical and mental decline in older people is not inevitable. While some changes with age are normal, many others can be avoided.

Although about half of the Nation's nearly one million elderly living in long-term care institutions are there because they were diagnosed as senile, that diagnosis is not always justified.

A mistaken diagnosis may be made because physicians and families may attribute mental decline and behavioral changes associated with physical conditions to senility, and fail to initiate appropriate and timely treatment.

Among the many causes of apparent senility which can be treated to reverse the condition are drug interactions, depression, metabolic disorders (thyroid, kidney, liver, and pituitary malfunction, as well as hypercalcemia and Cushing's Syndrome), chronic subdural hematoma, certain tumors, alcohol toxicities, chemical intoxications (arsenic and mercury), nutritional deficiencies, sensory deprivation due to social isolation or failing sight or hearing, chronic infections, hypoxia or hypercapnia associated with chronic lung disease, and anemia.

So numerous are the reversible causes of mental impairment that comprehensive diagnostic evaluation is often indicated. Moreover, there is growing

consensus among authorities that even with irreversible organic brain syndrome measures are available to lessen patient discomfort, to slow or arrest deterioration, and to help the patient make use of residual strengths.

Emphasis needs to be given, too, to the potentially adverse effects of the many and varied drugs prescribed for the elderly. Surveys indicate that older people often have more medications prescribed for them than really needed--a danger which is frequently overlooked.

Evidence is accumulating to show that in older people the body's handling of drugs is quite different compared with the younger adults on whom drug clinical trials are usually performed. Moreover, the elderly, often suffering from multiple chronic diseases, follow complicated drug regimens that can lead to unanticipated drug interactions.

The mental confusion, and other untoward effects on physical health caused by drugs and drug interactions, can be minimized if older people have access to a continuing, well-informed source of medical care, with proper attention given to only needed and suitable drugs and to patient education about drugs and drug effects.

At some point, too, elderly people are likely to need health or social system support because of social isolation, a dramatic change in their lives such as retirement, loss of a spouse, reduced income, or disease or injury.

Among the most frequent chronic conditions and impairments for older people in the community are: arthritis, which affects 44 percent of those over 65; reduced vision, 22 percent; hearing impairments, 29 percent; heart conditions, 20 percent; and hypertension, 35 percent. The elderly also, regardless of whether they are chronically limited in activity or mobility, are subject to an average of 5.5 weeks of short-term restricted activity a year. One third of this results from acute illnesses or injuries.

Some acute episodes, such as burns, falls, or influenza and pneumonia, may be preventable.

Although most of the elderly are able to assess their own health status quite reliably, they may not always seek needed attention promptly. The problem may be due in part to unavailability of needed services, especially in rural communities. But it may also be related to fatalism, fear of confinement, poor transportation, or economic factors.

Communities would do well to develop outreach programs to find the sick and disabled in this population and help them quickly--when help can be most effective as well as most economical.

The potential of such programs has been demonstrated in a four-year study in Texas: the average number of short stay hospital days for mental illness patients 65 and over was reduced from 111 to 53 in a county that had a vigorous outreach and referral program; a similar county without such a program retained an average of 114 hospital days for similar patients.

Programs of geriatric screening can have great value in finding still-minor disabilities which, if left undiagnosed and untreated, can lead to severe handicap. Such conditions which are very much amenable to early detection and treatment include glaucoma, hypertension, some types of anemia, depression, hearing disorders, diabetes, some cancers, and over-medication.

The objective of an early detection program should be to preserve physical and mental health and enable older people to remain in their homes for as long as they wish and are able to do so. The screening should consist of systematic examination covering total physical, mental and social health.

Health surveillance and health maintenance for the elderly are most effective when a comprehensive, integrated system of geriatric services is provided at a single location.

One reason is that many of the conditions common among the aged are linked with other conditions. Diabetes, for example, may be associated with peripheral blood vessel disease which requires good foot care. But visual impairment, common in elderly diabetics, makes such care difficult and limited mobility due to arthritis may compound the problem.

Special diets may be necessary for people with diabetes, heart disease, or hypertension. Diets of elderly people are more likely to be deficient--in calcium, iron and fiber, for example--than those of the rest of the population. Taste and smell alterations in older people may diminish enjoyment of food, creating difficulties in satisfying nutritional needs. And absence of teeth, problems with dentures, and gum disease can make the situation worse.

Many elderly people, therefore, need a range of services--dietary guidance, eye care, foot care, dental care, and social assistance, as well as routine medical care. And these are best provided at one center.

Social and Psychological Factors of Dependency

Abrupt changes in social dynamics--and the elderly often face them--can create severe emotional stress and lead to serious physical illness, even premature death.

Older people are especially likely to experience drastic changes in family circumstances as spouses die and children move to other cities.

The stress of loss and grief is compounded by the absence of support which a family can provide. Stress is exacerbated still more when death of a spouse forces the survivor to change living arrangements and move to unfamiliar surroundings.

The elderly, too, must adjust to the change in status which comes with retirement--including the associated financial constraints many experience.

Although the number of older people living in poverty has dropped by 60 percent since 1959, due in large measure to Social Security benefits, still 14 percent of older Americans have incomes below the poverty level--a proportion higher than for the population as a whole (less than 12 percent).

Moreover, elderly blacks are affected to much greater extent; 36 percent have below-poverty income levels. And women are constrained--with median incomes only about half those of men ($3,100 annually versus $5,500 for men in 1977).

Fear of the cost of severe illness may cause older people to conserve their limited financial resources. They select cheaper foods and housing, and make more limited use of preventive health services. Too often, the fear--let alone the reality--of financial straits prevents elderly people from leading the full and active lives of which they are capable.

Depression, a significant problem, may reflect loss of purpose in life. It is also related to presence of physical disease, loss of friends and relatives, other social difficulties, economic problems, and sometimes side effects of drugs often used by the elderly for such conditions as Parkinson's disease and hypertension.

Depression can be mentally and emotionally devastating, responsible for suicide or for seeming senility which may lead to needless institutionalization. It can exacerbate existing physical symptoms and may provoke new physical symptoms.

Many kinds of care and services are needed to deal with the complex, interrelated social, mental, and physical aspects of aging.

Limited dependency need not lead inexorably to total dependency. All who are functionally dependent, whether for a physical or mental condition, must be allowed--and encouraged--to do as much as possible for themselves, otherwise their abilities may deteriorate rapidly.

Absence of opportunity to choose among care and service options--as well as to participate in everyday tasks and decisions--is likely to produce apathy and accelerate dependency. The opportunity for choice not only promotes health; it also helps preserve individual dignity and sense of worth.

We know now what programs and services can help prevent deterioration, avoid needless institutionalization, and maintain functional independence.

They include programs for: safe and affordable housing; nutritious food availability through "meals on wheels" and group meal services; communication and transportation services, including telephones and escorts; recreation and education programs to promote enjoyment, challenge and stimulation; community centers to offer social opportunities; in-home services such as homemaker, visiting nurse, and home health care; ready access (including by telephone) to advice from a health professional; provision of eyeglasses, hearing aids, talking books, and large print publications; legal aid and counseling services; volunteer and employment opportunities to provide a continuing sense of purpose in life; and, not least of all, exercise.

Exercise and fitness for older people need emphasis. Aging is not--or should not--be a process of mere passivity. Nor should the obsolescent image of inevitable incapacitation be allowed to continue. Movement is part of functional living--and the quality of intellectual and physical performance is enhanced by remaining or becoming physically fit in old age.

Evidence for the viability of activity in enhancing function in old age is being developed through long-range studies such as those of the Gerontology Center of the University of Southern California. These studies indicate that people in their sixties and seventies and even beyond can retain, with carefully planned exercise, much of the vigor of their forties.

Older people can be more functionally independent.

Subgoal: Reducing Premature Death from Influenza and Pneumonia

In 1977 influenza and pneumonia together constituted the fourth leading cause of death among older people.

It may be true that for some of the elderly who are in late stages of physical and mental deterioration, death from these acute infections may not be untimely. Pneumonia has been called the "old man's friend" for the painless ending of life it may provide.

But many deaths occur in older people otherwise healthy and with much yet to live for. They can be prevented.

The greatest risk from the yearly influenza outbreaks occurs among the chronically ill and elderly.

A person over 75 is more than 10 times as likely to die of influenza as someone aged 55 to 64. Many of the chronically ill also are older persons. Chronic conditions which increase risk include: heart, lung, and kidney disease; diabetes and other metabolic disorders which increase susceptibility to infections; severe anemia; and diseases, including some malignancies, which compromise the body's defensive immune system.

For all high-risk individuals, annual vaccination against influenza is recommended--and those over age 65 should therefore seek the advice of public health authorities and personal physicians.

For pneumococcal pneumonia, we now have a significant development. This lung infection has been responsible for 54,000 deaths a year. Even with antibiotic treatment, it has been a serious threat to older people. The death rate has been 2.5 times higher for those aged 65 to 74, and 10 times higher

for those 75 to 84, than for the population as a whole.

A newly-developed pneumococcal vaccine promises to be an effective preventive measure--particularly for special populations of the elderly, such as those in nursing homes and institutions where, because of close contact, disease spread is more rapid.

And prevention of both influenza and pneumococcal pneumonia can be vital for people with chronic lung diseases. Bronchitis, emphysema, and asthma are prevalent among the elderly and together constitute the eighth leading cause of death after age 65. The elderly with such conditions cannot tolerate well the added burden of acute respiratory infections.

Other Important Problems

Of American babies born today, three-fourths can expect to reach age 65; almost half will reach 75; and one-fourth will reach age 85.

Although many people are living longer, there appears to be a biological limit to the lifespan and it seems unlikely that, at least for the near future, any spectacular further gains in life expectancy can be anticipated.

While long life is desired by people in all cultures, quality of life may be even more important. And Americans now are witnessing the emergence of a new concept of aging.

It calls for the highest possible level of health throughout the later years--and, finally, dignified circumstances at the end of life.

It considers that a healthy society will view old age--and the inevitable death at its end--not as unnatural, but an integral part of the life span.

And it calls for society to learn how to help those for whom medical care can offer no more, so

that death becomes possible without pain, discomfort, humiliation or financial worries.

A very real concern of the elderly is a prospect of being exposed to sophisticated technology that prolongs life beyond the time when it is meaningful and enjoyable. Nor can they view a busy, impersonal hospital as a comfortable setting for an individual who is dying. They have an additional anxiety: that the high costs of extended hospital stay place a heavy financial burden on surviving spouse or other family members.

Fears and anxieties about conditions surrounding death can be reduced.

When it becomes apparent that death is at hand, the health care system should be willing to accept the obligation to allow it to happen with as little pain and suffering as possible. The patient should be allowed to be in peaceful surroundings, preferably at home. Last year, most older Americans died away from home. When death is near, the greatest comfort lies in being in a home setting amidst the comfort and support that family members can provide.

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Many health problems of the elderly reflect past environments and lifestyles. The occurrence of heart disease, stroke, cancer, and other chronic afflictions may be rooted in earlier life.

When these conditions no longer can be avoided through preventive measures, early diagnosis and treatment very often can postpone death, avoid serious complications, and minimize pain, disability and emotional anguish.

Some health problems may be as much the result of basic human biology as of environment and lifestyle. Arthritis, diabetes, and some types of cancer, for example, may arise from changes in structure and function of aging cells. Even though knowledge is not now available to prevent these diseases, their course can be influenced.

There remain, too, many preventable conditions to which older people are vulnerable--including those such as influenza and pneumococcal pneumonia for which immunizations are available, and those caused or intensified by poor nutrition, lack of exercise, and other lifestyle deficiencies.

Thus, many measures can be applied to increase independence, self-sufficiency and quality of life for the elderly.